



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

DR CHARLES POLSEN  
2622 MARINA BAY DRIVE  
LEAGUE CITY TX 77573

DWC Claim #:  
Injured Employee:  
Date of Injury:  
Employer Name:  
Insurance Carrier #:

#### **Respondent Name**

TEXAS MUTUAL INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 54

#### **MFDR Tracking Number**

M4-12-1356-01

#### **MFDR Date Received**

JANUARY 3, 2012

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "The requestor did not submit a position summary with the request for medical fee dispute resolution."

**Amount in Dispute:** \$13,510.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The requestor provided outpatient surgical services to the claimant on 9/8/11 and then billed Texas Mutual codes 26145, 64702, 64727, and 64450... The requestor's documentation does not substantiate that the claimant's report of pain was related to a serious dysfunction of any body organ or par [sic], or that waiting for the preauthorization decision would have placed the claimant's health or bodily functions in serious jeopardy. Absent such documentation the requestor provided surgical treatment without the requisite authorization. No payment is due."

**Response Submitted by:** Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 8, 2011	CPT Codes 26145 x 2; 64702-59 x 2; 64727-59 x 2 and 64450-59 x 2	\$13,510.00	\$2,765.43

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the procedure for obtaining preauthorization for specific treatments and services.
3. 28 Texas Administrative Code §133.2, effective July 27, 2008, 33 TexReg 5701, defines a medical emergency.

4. 28 Texas Administrative Code §134.203 sets out reimbursement guidelines for professional services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 18 – Duplicate Claim/Service.
- 197 – Precertification/Authorization/Notification absent.
- 224 – Duplicate Charge.
- 930 – Pre-authorization required. Reimbursement denied.

### **Issues**

1. Did the disputed services require preauthorization?
2. Is the requester entitled to reimbursement?

### **Findings**

1. Per 28 Texas Administrative Code §134.600(c)(1)(A) and (B), states “The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur:

(A) An emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

(B) Preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care.”

28 Texas Administrative Code §134.600(p)(2) states “Non-emergency health care requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section.”

28 Texas Administrative Code §133.2(3) defines “Emergency – Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

- (i) Placing the patient’s health or bodily functions in serious jeopardy, or
- (ii) Serious dysfunction of any body organ or part.”

Review of the operative note states “... the patient presented yesterday afternoon saying that the pain has actually gotten worse. It was so severe and intense and incapacitating that the claimant had cried 3 times that day and actually stated that he would ‘cut his finger off’ if I could not operate on him ..., his pain was severe, and he absolutely required surgery....” The division finds that the medical condition described in the submitted documentation meets the definition of an emergency pursuant to §133.2(3). For that reason, the disputed services did not require preauthorization per 28 Texas Administrative Code §134.600(p)(2). The disputed services will therefore be reviewed per the applicable Division rules and the fee guideline.

2. 28 Texas Administrative Code §134.203(c) states, in pertinent part, “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) ... For surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32... (2) Subsequent year’s conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year’s conversion factors, and shall be effective January 1st of the new calendar year.” The MAR for the payable services may be calculated by (2011 TDI-DWC Surgery Conversion Factor / MEDICARE CONVERSION FACTOR) x Facility Price = MAR.
  - CPT Code 26145 -  $(68.47 \div 34.023) \times \$486.48 = \$979.02$
  - CPT Code 26145 -  $(68.47 \div 34.023) \times \$486.48 = \$979.02$  x application of multiple procedure discount of 50% = \$489.34
  - CPT Code 64702 -  $(68.47 \div 34.023) \times \$463.31 = \$932.39$  x application of multiple procedure discount of 50% = \$466.20 x 2 units = \$932.40
  - CPT Code 64727 -  $(68.47 \div 34.023) \times \$181.12 = \$364.50$  x application of multiple procedure discount of 50% = \$182.25 x 2 units = \$364.50
  - CPT Code 64450 is a component procedure of 64702; these codes are considered unbundled and a modifier is not allowed. As a result, the amount ordered for this code is \$0.00

Review of the submitted documentation finds that the requestor has sufficiently supported the treatment provided meets the definition of a medical health emergency. As a result, the amount ordered is \$2,765.43.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$2,765.43.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$2,765.43 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

_____	_____	March 22, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**